SAMWUMED

Real Heritage. Real People. Real Health Care.

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APPLICATION TO REGISTER DEPENDANTS PM002

Please use black or blue ink when completing this form. Where appropriate mark your selection with an "x".

A. PERSONAL PARTICULARS – COMPLETE BLOCKS FROM LEFT TO RIGHT, ONE LETTER PER BLOCK

Title (Dr, Mr, Mrs or Miss) Initials Membership number

Surname

First name(s)

Date of birth D D M M Y Y Y Y Identity/passport number

Telephone (H) (W)

Fax Cellphone

E-mail address

Postal address

Postal code Staff Number

Province Municipality

Marital status Married Single Divorced Widow/er Gender M F

B. ORDINARY DEPENDANTS DETAILS *(When registering your wife, include her maiden surname.)*

If your dependants reside at a different address from the one provided in Section A, please include it below.

First name and surname Identity number Gender Relation

1. M F

Physical address

Postal code

Telephone Cellphone

First name and surname Identity number Gender Relation

2. M F

Physical address

Postal code

Telephone Cellphone

First name and surname Identity number Gender Relation

3. M F

Physical address

Postal code

Telephone Cellphone

Member number

Continued overleaf ▸

B. DEPENDANT DETAILS – CONTINUED

4.
First name and surname | Identity number | Gender M F | Relation

Physical address

Postal code

Telephone | Cellphone

5.
First name and surname | Identity number | Gender M F | Relation

Physical address

Postal code

Telephone | Cellphone

Note: In order to register yourself and your dependant/s, please attach copies of the following supporting documents: identity documents, marriage certificate and/or birth certificates. Sworn affidavits are required for children born outside of marriage, life partners and/or cultural marriages.

C. SPECIAL DEPENDANTS

If your dependants reside at a different address from the one provided in Section A, please include it below.

1.
First name and surname | Identity number | Gender M F | Relation

Physical address

Postal code

Telephone | Cellphone

2.
First name and surname | Identity number | Gender M F | Relation

Physical address

Postal code

Telephone | Cellphone

3.
First name and surname | Identity number | Gender M F | Relation

Physical address

Postal code

Telephone | Cellphone

Note: In order to register yourself and your dependant/s, please attach copies of the following supporting documents: identity documents, marriage certificate and/or birth certificates. Sworn affidavits are required for children born outside of marriage, life partners and/or cultural marriages.

Member number

Continued overleaf ▸

D. MEDICAL HISTORY

Please note: failure to disclose medical conditions could limit and/or exclude your dependants from receiving certain benefits. If more than two of your dependants are affected by the same condition please attach the required information to this application form on a separate sheet.

1. Do any of your dependants suffer from a chronic illness (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, depression, anxiety, epilepsy, and/or thyroid disorders)? YES NO

   If yes, please provide details below.

Name of beneficiary	Name of condition	Name of medication	Is he/she currently receiving treatment?		Date/frequency of treatment	Attending doctor
			YES	NO		
			YES	NO		

2. Do any of your dependants suffer from any gastro-intestinal disorders (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative colitis, diverticulus and/or spastic colon)? YES NO

   If yes, please provide details below.

Name of beneficiary	Name of condition	Name of medication	Is he/she currently receiving treatment?		Date of treatment	Attending doctor
			YES	NO		
			YES	NO		

3. Do any of your dependants suffer from muscle, bone, skin or nerve illnesses or disorders (e.g. back- and neck-related conditions including injury, arthritis, gout, multiple sclerosis, knee and/or hip problems)? YES NO

   If yes, please provide details below.

Name of beneficiary	Name of condition	Name of medication	Is he/she currently receiving treatment?		Date of treatment	Attending doctor
			YES	NO		
			YES	NO		

4. Do any of your dependants suffer from urinary or genital disorders (e.g. kidney stones, prostate, endometriosis, ovarian cysts and/or menstrual disorders)? YES NO

   If yes, please provide details below.

Name of beneficiary	Name of condition	Name of medication	Is he/she currently receiving treatment?		Date of treatment	Attending doctor
			YES	NO		
			YES	NO		

5. Do any of your dependants suffer from ear, nose or throat disorders (e.g. glaucoma, cataracts, visual disorders, deafness, rhinitis and/or orthodontics)? YES NO

   If yes, please provide details below.

Name of beneficiary	Name of condition	Name of medication	Is he/she currently receiving treatment?		Date of treatment	Attending doctor
			YES	NO		
			YES	NO		

6. Do any of your dependants suffer from any blood disorders, immune deficiency state, HIV/Aids, cancer and/or any other life threatening illness. YES NO

   If yes, please provide details below.

   If any of your dependants are living with HIV/Aids, it would be in their best interest to register on SAMWUMED's HIV Management Programme immediately upon approval of your membership. Should your dependants only find out at a later stage that you are HIV-positive, please let us know as soon as possible.

Name of beneficiary	Name of condition	Name of medication	Is he/she currently receiving treatment?		Date of treatment	Attending doctor
			YES	NO		
			YES	NO		

Member number | | | | | | | | | | | | | |

Continued overleaf ▸

D. MEDICAL HISTORY – CONTINUED

7. Are any of your dependants pregnant? YES NO

Name of beneficiary	Expected delivery date	Attending doctor

8. Have any of your dependants had surgery in the past, or are they planning to have a surgical procedure done in the next 12 months? YES NO

   If yes, please provide details below.

Name of beneficiary	Name of condition	Name of medication	Is he/she currently receiving treatment?	Date of treatment	Attending doctor
			YES NO		
			YES NO		

9. Is there any condition or symptoms other than those listed above, for which medical advice, diagnosis, care or treatment has been recommended or received or could potentially result in a claim in the next 12 months? YES NO

   If yes, please provide details below.

Name of beneficiary	Name of condition	Name of medication	Is he/she currently receiving treatment?	Date of treatment	Attending doctor
			YES NO		
			YES NO		

CURRENT DOCTOR

Name and surname

Telephone number

How many months/years has he or she been your doctor?

E. MEMBER DECLARATION

I hereby apply to register the above-mentioned dependant(s) with SAMWU National Medical Scheme (SAMWUMED) and agree to abide and be bound by the Rules of the Scheme. I certify that the answers provided in my application are true and correct. I hereby authorise my employer to deduct, from my salary/wages, any amount(s) owed to SAMWUMED and remit such amounts to the Scheme on my behalf. **I am aware that the Scheme may impose general and/or condition-specific waiting periods as provided for in the Medical Schemes Act 131 of 1998.** I confirm that I am ultimately responsible for ensuring that my contribution is received by the Scheme each month.

I confirm that I understand and am familiar with the benefits of the Option I have selected.

I authorise my healthcare provider or any other party who may be in possession of information concerning my dependant/s' health to disclose such information to SAMWUMED and its business partners, provided that such information shall be kept confidential at all times. Such confidential health and personal information will only be used for purposes as outlined on this form.

I will inform the Scheme within 30 days of any changes in my dependant/s' health or personal status as required by the Scheme Rules.

I consent to the recording of all conversations between myself and the Scheme or its contracted business partners.

Applicant's signature _____ Date of application D D M M Y Y Y Y

Please submit this application to your HR for approval before sending to the Scheme.

F. SCHEME DECLARATION

SAMWUMED confirms that all health or personal information concerning the applicant's dependant/s will be kept confidential and will request the applicant's signed consent for the transfer and disclosure of health and personal information.

The Scheme will endeavour to obtain further consent from the applicant should confidential health and personal information be used for purposes other than those outlined in this application.

EMPLOYER'S OFFICIAL STAMP

Member number